STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 120335-001**

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this _14th_ day of September 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On March 30, 2011, XXXXX, authorized representative of XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on April 6, 2011.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on April 15, 2011.

Because medical issues were involved, the case was assigned to an independent review organization which provided its analysis and recommendations to the Commissioner on April 20, 2011.

II. FACTUAL BACKGROUND

The Petitioner's health care benefits are defined in BCBSM's *Comprehensive Hospital Care Group Benefit Certificate* (the certificate).

Following acute hospital care, the Petitioner was admitted to a skilled nursing facility (SNF) on August 3, 2010, and discharged on September 20, 2010.

BCBSM approved and covered skilled nursing care from August 3 through August 27, 2010, and again from September 7 through September 20, 2010. However, BCBSM determined the Petitioner did not require skilled care from August 28 through September 6, 2010, and coverage for that period was denied.

The Petitioner appealed the denial through BCBSM's internal grievance process. BCBSM held a managerial-level conference on January 19, 2011, and issued a final adverse determination dated February 3, 2011, upholding its denial.

III. ISSUE

Did BCBSM correctly deny coverage for the Petitioner's nursing facility care from August 28 through September 6, 2010?

IV. ANALYSIS

BCBSM's Argument

It is BCBSM's position that the need for skilled care must be established if a stay in a skilled nursing facility is to be covered. BCBSM states that not all of the Petitioner's care at the SNF required skilled care; that in fact she left the SNF for two days (September 2 and September 3, 2010) and stayed with her family. BCBSM further noted that the Petitioner's medical records reflect that she did not receive any skilled therapies from August 20 through August 29, 2010, or from September 4 through September 6, 2010.

BCBSM's medical consultants determined that during the period from August 28 through September 6, 2010, the Petitioner was performing at a high functioning level and there was no medical instability or need for skilled nursing care during that time. BCBSM maintains that the care during that period could have been provided in a non-skilled setting.

Petitioner's Argument

It is the Petitioner's position that she was under the supervision of a physician during the period of time she was at the SNF and that the physician certified the need for skilled nursing care during her entire stay in the facility.

The Petitioner believes that her therapy and medical records from the facility support her assertion that all of her care was skilled. She believes that BCBSM is required to cover all of her stay at the SNF.

Commissioner's Review

The certificate (p. 5.17) defines skilled care:

> A level of care that can be given only by a licensed nurse to ensure the medical safety of the patient and the desired medical result. Such care must be:
>
> - Ordered by the attending physician
> - Medically necessary according to generally accepted standards of medical practice
> - Provided by a registered nurse or a licensed practical nurse supervised by a registered nurse or physician

The question of whether it was medically necessary for the Petitioner to receive skilled care from August 28 to September 6, 2010, was presented to an independent review organization (IRO) for analysis as required by Section 11(6) of the Patient's Right to Independent Review Act, MCL 550.1911(6). The IRO reviewer is board certified in internal medicine and geriatrics, holds an academic appointment, and has been in active practice for more than 12 years. The IRO report contained the following:

> The MAXIMUS physician consultant explained that nursing notes from 8/28/10 to 9/6/10 document that the member remained medically stable. The MAXIMUS physician consultant also explained that based on the records provided for review, the member had no daily skilled nursing needs from 8/28/10 to 9/6/10 that required treatment in a skilled nursing facility setting. The MAXIMUS physician consultant indicated that the member received skilled physical and occupational therapy and reached her maximum functional potential. The MAXIMUS physician consultant noted that the member was at a stand-by assistance level for functional mobility including ambulation to 150 feet and required stand-by assistance to contact guard assistance for activities of daily living. The MAXIMUS physician consultant explained that further significant progress was not expected with continued daily rehabilitation from 8/28/10 to 9/6/10. The MAXIMUS physician consultant also explained that the member's rehabilitation needs could have been met at a lower level of care during the period at issue in this appeal.
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> Pursuant to the information set forth above and available documentation, the MAXIMUS physician consultant determined that it was not medically necessary for the member to have been treated at a skilled nursing facility level of care from 8/28/10 to 9/6/10.

While the Commissioner is not required in all instances to accept the IRO's recommendation, it is afforded deference. In a decision to uphold or reverse an adverse determination, the Commissioner must cite "the principal reason or reasons why the Commissioner did not follow the assigned independent review organization's recommendation." MCL 550.1911(16) (b). The IRO reviewer's analysis is based on expertise and professional judgment and the Commissioner can discern no reason why the recommendation should be rejected in this case.

The Commissioner accepts the conclusion of the IRO and finds that BCBSM's denial of coverage was correct under the terms of the certificate.

V. ORDER

BCBSM's final adverse determination of February 3, 2011, is upheld. The Petitioner did not require skilled care from August 28 to September 6, 2010.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner